TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Michael W. Mann, M.D.

Respondent Name
Old Republic Insurance Company

MFDR Tracking Number
M4-16-1820-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
March 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $1165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider was ordered to perform a Return to Work Examination. He performed this examination and billed $500.00 for this portion of the examination. He was reimbursed this full amount. The $15.00 extra charged by the provider for the DWC-73 completion was not reimbursed as the Designated Doctor's Return to Work Examination fee was included this charge."

Response Submitted by: White Espey, PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 27, 2015	Designated Doctor Examination	$1165.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 5141 – Bill has been reviewed by a nurse or under the direction of a nurse.

- 4151 – An allowance was not paid for the work status report. Reimbursement to RME doctors and designated doctors for the report is included in the reimbursement for the examination.
- W3 – Additional payment made on appeal/reconsideration.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- OA – The amount adjusted is due to bundling or unbundling of services.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.
- PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary.

Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of $1150.00 for a Designated Doctor Examination for the Determination of maximum medical improvement (MMI), impairment rating (IR), and the ability of the injured employee to return to work (RTW). The requestor is also seeking reimbursement of $15.00 for a Work Status Report (DWC073).

   Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204(j)(4), "The following applies for billing and reimbursement of an IR evaluation. … (C)(ii) The MAR for musculoskeletal body areas shall be as follows. … (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The submitted documentation supports that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the lumbar spine. Therefore, the correct MAR for this examination is $300.00.

   Per 28 Texas Administrative Code §134.204(k),

   > The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

   The submitted documentation indicates that the Designated Doctor performed an examination to determine the injured employee's ability to return to work. Therefore, the correct MAR for this examination is $500.00.

   Per 28 Texas Administrative Code §134.204(l), "The following shall apply to Work Status Reports. When billing for a Work Status Report **that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section** [emphasis added], refer to §129.5 of this title (relating to Work Status Reports)". Therefore, the filing of the DWC-073 is not separately payable when provided in conjunction with a Designated Doctor Examination performed according to 28 Texas Administrative Code §134.204(i). The division concludes that the examination in question was performed in accordance with 28 Texas Administrative Code §134.204(i). Therefore, this disputed service is not separately payable.

2. The total MAR for the disputed services is $1150.00. Per the explanation of benefits dated November 26, 2015, the insurance carrier paid $1150.00. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	April 6, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.